

HEALTH CARE TRANSITION

FROM PEDIATRIC TO ADULT PRIMARY CARE

**GUIDE FOR PHYSICIANS TO SUPPORT YOUTH AND YOUNG ADULTS
WITH SPECIAL HEALTH CARE NEEDS**

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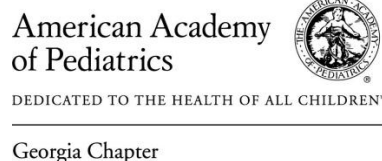
Health Care Transition from Pediatric to Adult Primary Care

Guide for Physicians to Support Youth and Young Adults with Special Health Care Needs

**Sponsored by
Georgia Department of Public Health
Maternal and Child Health Section
Two Peachtree Street, NW
Atlanta, GA 30303**

Funded by the Georgia Department of Public Health through the State Implementation Grants for Integrated Community Systems for CSHCN (D70MC24121) from the Federal Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), of the U.S. Department of Health and Human Services (DHHS).

The Georgia Department of Public Health, in collaboration with the Georgia Chapter, American Academy of Pediatrics and the Georgia Academy of Family Physicians offers this guide herein to support transitioning young adults with special health care needs to adult care.



2014

ACKNOWLEDGEMENTS

The Maternal and Child Health Section of the Georgia Department of Public Health would like to thank the following organizations and individuals for their participation and contributions.

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Health Care Transition from Pediatric to Adult Primary Care

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October 1, 2014

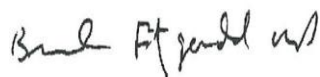
Dear Healthcare Provider,

According to the National Survey of Children with Special Health Care Needs, in 2009/10 only 40% of Youth with Special Health Care Needs (YSHCN) between the ages of 12 and 17 had a health care provider discuss transition planning with them and their family. While most youth transition successfully from pediatric to adult health care, many YSHCN require planning, guidance, and support. The pediatric primary care physician plays a vital role in the lives of their patients, as well as in the transition process. Because of the close relationships, frequency of contact, and the level of understanding of the needs of their patients, the primary care physician is best qualified to help their patients prepare for this next phase in their lives.

In an effort to encourage and support transition planning for YSHCN, the Georgia Department of Public Health, Georgia Chapter, American Academy of Pediatrics, and Georgia Academy of Family Physicians collaborated on the development of this valuable resource guide for physicians. The *Health Care Transition from Pediatric to Adult Primary Care* guide provides resources and strategies to help physicians support their patient's successful transition. We believe this resource will be of benefit to you and your patients and hope you will utilize it frequently.

We are appreciative of the expertise and support we have received from our partners at the Georgia Chapter, American Academy of Pediatrics and Georgia Academy of Family Physicians. We look forward to continued collaboration on future projects.

Sincerely,



Brenda Fitzgerald, M.D.
Commissioner, State Health Officer



American Academy of Pediatrics



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Dear Colleague,

As a general pediatrician, I often find myself in the role of transitioning my patients to adult care. These transitions are supported throughout the later teen years and can be any one of the following scenarios (1) the healthy adolescent transferring to adult care; (2) the adolescent with a chronic illness in need of adult primary and specialty care; and (3) the adolescent with a life threatening illness in need of adult primary and specialty care. The goals in supporting transitions include supporting adolescents in:

- Understanding their health care needs and how to manage them,
- Advocating for themselves and communicating their health care needs, and
- Realizing their goals in life in ongoing education, career, and personal life.

Depending on their health history, adolescents and their families can face a variety of challenges in their effort to transition. These challenges can include access to adult specialists knowledgeable about pediatric diseases/disorders as well as health coverage for needed services.

The Health Care Transition for Youth with Special Health Care Needs: An Analysis of National and State Performance updated in February 2012 indicate that youth across the country are in need of support to successfully transition from pediatric to adult health care. Only 41% of our Nation's youth successfully transition to adult care; in Georgia the rate is 37 %. Primary care pediatricians providing a medical home to these adolescents play an integral role in helping the adolescent patients understand their health care needs, becoming comfortable in making health care decisions, identifying an adult health care provider, and maintaining insurance coverage. This guide is meant to provide resources and tools for the primary care pediatrician in supporting their adolescent patients in successfully transitioning to adult care.

The primary elements included in this guide come from the Center for Medical Home Initiatives and Got Transitions. This guide provides a comprehensive list of resources to support transitions for the practice that is just beginning to implement a system of transitions in their practice to materials to enhance efforts that have already begun in a practice.

We hope to continue our collaboration with the Department of Public Health, the Georgia Academy of Family Physicians and the American College of Physicians to support these efforts in your practice.

Welcome to the Journey!

Sincerely,

A handwritten signature in black ink that reads "Evelyn D. Johnson MD FAAP".

Evelyn Johnson, MD
American Academy of Pediatrics
Georgia Chapter
Chapter President, 2014





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Brian K. Nadolne, MD, FAAFP
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October 21, 2014

This guide serves as a road map for physicians who are about to embark on, or are currently, treating young adults that are transitioning from pediatric to adult care. Family physicians work closely with pediatric subspecialties to provide a continuation of services and address medical concerns with the understanding that in some situations there may also be developmental, emotional and social barriers to medical care. The goal of family medicine is to provide a patient centered model of care which encompasses all specialty care. Some young adults are healthy and require only the continuation of health maintenance such as annual visits; however when the patient is faced with acute illness the patient is in need of a patient centered medical home.

The medical home provides care that is family centered, accessible, coordinated and comprehensive. For example, resource coordinators are available to assist patients by making appointments to specialty care, coordinating treatment when necessary, and providing assistance with transportation resources to treatment locations.

The unique relationship that develops with the family physician and the young adult serves as the base for the patient centered medical home, with access to care that is continuous throughout the patient's life journey.

We hope to continue our collaboration with the Georgia Department of Public Health, the Georgia Chapter of the American Academy of Pediatrics and the Georgia Chapter of the American College of Physicians to support these efforts in your practice.

Sincerely

Brian K. Nadolne, MD
Georgia Academy of Family Physicians
Chapter President, 2014



INTRODUCTION

The **purpose of this guide** is to help the general primary care pediatrician and family medicine physician **begin the conversation of transition to adult primary care** with their early adolescent patients and successfully transitioned older adolescents. We will begin by providing an overview of transition, review the current state of transition, and offer resources to support health care transition for you to use with your patients and their families.

Medical Settings and Types of Transitions

Primary Care Pediatrics	Family Medicine Primary Care	Med/Peds	Internal Medicine
<ul style="list-style-type: none">• The Bright Futures/AAP Periodicity Schedule recommends annual physicals up until the child reaches 21 years of age.• Children and Youth with Special Health Care Needs are often managed by a variety of care providers depending on their health status.• It is recommended that primary care pediatricians begin discussing transitioning to adult care as early as 12 years of age.	<ul style="list-style-type: none">• In these types of medical practices, adolescents remain in practice but transition should occur because history taking, care decision making, and the relationship with the provider will change for both the family and the adolescent over time.	<ul style="list-style-type: none">• In these types of medical practices, adolescents remain in practice but transition should occur because history taking, care decision making, and the relationship with the provider will change for both the family and the adolescent over time.	<ul style="list-style-type: none">• In these types of medical practices, adolescents seek care between the ages of 18 - 21.• A complete health history is important to be shared by the adolescent so that their care can be appropriately managed.

Successful transition involves the adolescent patient, the family of the patient, their primary care pediatrician and their adult health care physician; **all have key roles in supporting a successful health care transition**. Each also must assess their readiness to begin the health care transition process.

Within the Pediatric Primary Care model, the adolescent patient has many transition questions which revolve around the following:



When should I begin looking for a physician who focuses on adults?



When should I begin jointly making health care decisions with you and my parents?



How should I begin taking a greater role in understanding my symptoms, triggers, and side effects of my disability or health care needs so that I can get the care I need?

Within the Family Medicine model, adolescent patients have similar transition-related questions as listed above. As the transition process progresses, additional questions are asked:



Do I qualify for continuous health insurance through my parents or do I qualify for Medicaid or Medicare coverage?



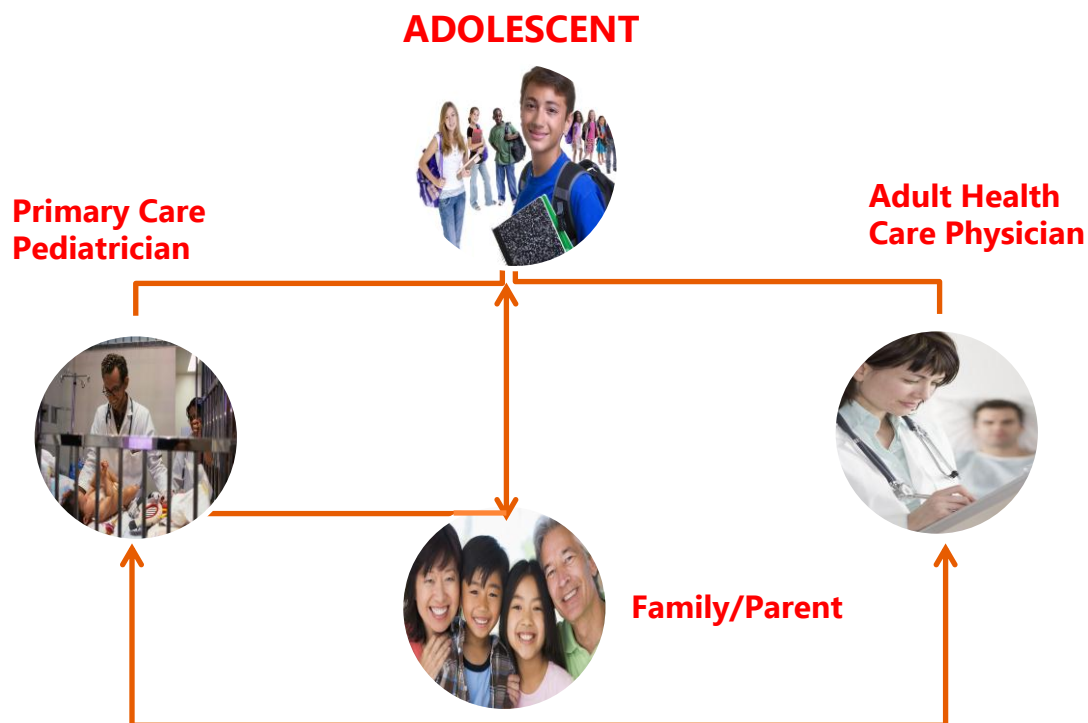
What information do you need to understand about my health conditions in order to manage my health care needs?



When should I receive regular physicals and routine screenings such as cholesterol, hearing, vision, blood pressure monitoring etc.

Adolescent – Youth readiness must be assessed to determine the best time to introduce them to taking the lead in making health care decisions and in managing their health care needs.

Family/Parent – Parent and family readiness must also be assessed to determine their openness and willingness to begin the process to allow their adolescent to begin making health care decisions. Parents may have established close ties with their child's primary care pediatrician and feel concerned about their diminishing role in managing their child's health care needs.



Primary Care Pediatrician – Pediatric medicine engages with parents and caregiver to support the physical, emotional and social health development of young children. As the child reaches adolescence, it is important for pediatricians to begin the transition process. This can occur by educating their adolescent patients in understanding their own individual health care needs and in soliciting their opinions on health care decisions. Youth must be supported in feeling empowered through the transition process to develop self-management skills and acquire tools they need to gain more control over their own lives. It is also important to address families' concerns and questions as adolescents approach legal adulthood at age 18.

Adult Health Care Physician – Family medicine focuses on family-centered, accessible, coordinated and comprehensive care. Today, family physicians provide the majority of care for America's underserved and rural populations. In the increasingly fragmented world of health

care where many medical specialties limit their practice to a particular organ, disease, age or sex, family physicians are dedicated to treating the whole person across the full spectrum of ages. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. Family physicians could be the primary provider of care for the pediatric patient or the physician receiving the adolescent/young adult as the patient transitions into a more adult medicine based care.

Section 1

Health Care Transition

Health care transition, according to the Society for Adolescent Medicine, is the **purposeful, planned movement of adolescents from pediatric to adult health care**. It is a “process” where the responsibility for managing health care shifts from the parent to the young adult. Health care transition is one aspect of the many transitions that occur in the movement from adolescence to adulthood. It is an active, multifaceted process that involves the medical, psychosocial, educational and vocational needs of youth. For those with special needs, transition can be especially challenging.

Youth with special health care needs (YSHCN) are *“those who experience significant health conditions that affect functioning on a daily basis, and require specialized accommodations or medical treatment”* (www.nichq.org, 2009). They have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions that persist into adulthood.

Approximately 30 percent of adolescents experience at least one or more of these conditions, such as ADD/ADHD, asthma, intellectual or developmental disability, cancer, autism, congenital heart disease, or sickle cell anemia to name a few.

Understanding the Issues

The need to focus on care of adolescents with chronic and disabling health conditions arose out of dramatically improved survival rates of children born since the 1970s. Today, most children with chronic disease and disability now survive into adulthood. It is estimated that more than 12 million children and youth in the United States have chronic conditions, with 500,000 to 750,000 reaching transition age each year. Almost half lack access to a physician familiar with their health condition.

In the United States, the conversations on transition for youth with special health care needs began with The Surgeon General’s report published in 1989 entitled, “Growing Up and Getting Medical Care: Youth with Special Health Care Needs.” This publication set forth a national agenda in training, research, and program development. The goal was to establish a seamless health care system that would allow young people with special needs to move successfully from pediatric to adult-centered services.

However, even with increased awareness and understanding, two decades later we have made little progress. Successful efforts to date have been primarily directed towards youth and families. Despite leadership efforts by the American Academy of Pediatrics (AAP) and others, planning for transition and the purposeful transfer to adult providers has yet to become a standard of care for most pediatric practices. Only in the past few years has it even been

acknowledged that adult care disciplines need to make a similar commitment to support transition care.

The Need for Health Care Transition Services

In 2001, the U.S. Department of Health and Human Services Maternal and Child Health Bureau sponsored a national meeting of leaders from primary and subspecialty care, multi-disciplinary professionals, and parents of youth with disabilities. This effort resulted in “A Consensus Statement on Health Care Transitions for Young Adults with Special Health Care Needs” adopted as policy by the American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians – American Society of Medicine. The goal was to ensure that by the year 2010, all physicians who provide care to youth with special health care needs will:

- Understand the rationale for transition from child-oriented to adult-oriented health care;
- Have the knowledge and skills to facilitate this process; and
- Know if, how, and when transfer of care is indicated.

There has been resurgence in efforts to realize these goals. Attaining them will require a change in our consciousness, systems of care and practice-based change. It will take a commitment to collaboration among providers, improved insurance coverage, better reimbursement, and educational tools for youth, parents, and medical providers.

Challenges to Transition

Like many medical home teams across the country, specialized training and technical assistance to support transition planning is needed.

Pediatricians and their staff must establish a transition policy, select a means of determining family and youth transition readiness, and establish relationships with adult care providers to provide linkage for their pediatric patients for adult care.

Similarly, adult care providers and medical subspecialists also may need to expand their readiness to provide services to youth with special healthcare needs; the care of youth with cognitive impairments and other special health care needs may require educational and clinical training.

Many pediatric subspecialists have been building their capacity to manage these transitions for their patients, who have survived childhood cancer, congenital heart defects, and other chronic health conditions like HIV AIDS, Sickle Cell and Diabetes. Still more needs to be established for those with ADHD, Autism Spectrum Disorders, and other Emotional and Behavioral Disorders.

Outcomes-related research efforts have, so far, failed to fully address the transition needs of adolescents with or without chronic conditions. A recent national survey revealed that pediatricians remain poorly informed about the conclusions of the consensus statement and that most pediatric practices neither initiate transition planning early in adolescence nor offer transition-support services, which have been found to be critical for ensuring a smooth transition to the adult health care model. Many pediatricians, youth, and families have found a limited availability of adult providers with whom to arrange a smooth transition of care.

In addition, evidence indicates that many adult providers feel unprepared to care for young adults with complex chronic conditions. In some cases, there is no identified adult primary care or specialty provider to who care can be transitioned. Lack of time, adequate payment, and training has been cited as major barriers to transition. Workforce shortages exist and are anticipated to worsen for physicians and other health professionals providing care for adults of all ages.

In the face of an aging population that needs care, these shortages may be an obstacle to the delivery of primary care to more young adults with or without special health care needs. Family physicians caring for youth note that no transfer of primary care will be needed; nevertheless, there is a need to implement an adult model of care; plan for the transfer of specialty care to adult medical subspecialists; and support broader transition planning that includes issues such as educational attainment, career choices, and independent living needs.

Internists find it challenging to care for a child or youth with special health care needs when the youth lacks preparation to be his or her own health advocate and the referring physician sends only minimal information about the youth and/or his or her condition.

What Does Successful Transition Look Like?

Successful health care transition is broader than just health care aspects in that the adolescent is also likely to encounter a change in:

- Living arrangements
- Transportation
- Postsecondary education
- Work
- Family and other social relationships
- Financial self-sufficiency and
- Encountering family culture concerns of their parents

All of these aspects influence a successful transition whether it relates to access to health care services and or the ability to travel to those health care services. Although physicians and others are involved in the adolescent's care it is important to recognize how these factors influence transitions.

A young adult has made a successful transition to adult health care services if he/she has met all of the following criteria:

- Usual health care source or personal doctor/nurse;
- Health care provider who did not treat only children, teens, or young adults;
- Health insurance coverage that meets his/her needs;
- At least one recent (within the past 12 months) preventive health care visit;
- Satisfied with health care services;
- No recently (within the past 12 months) delayed or foregone needed health care services.

Supporting your adolescent patients in transitioning from pediatric to adult medicine involves helping your adolescent patients to:

- Plan for their transition
- Empowering them to understand and manage their own health care needs
- Manage parent concerns
- Linkage to primary and specialty adult care
- Understand how to continue or find health insurance
- Learn to take care of their own health

Georgia's Opportunity to Improve Successful Transition from Pediatric to Adult Health Care

Georgia's service continuum for families of children and youth with special health care needs is a complex journey through a service delivery system comprised of multiple public and private health care providers including primary and specialty care providers, Medicaid regulations and medical equipment vendors. Some of the challenges faced by children and youth with special health care needs and their families in accessing a medical home and transition services to adult care services are further complicated by health care financing, transportation and provider shortages in some areas of the state.

In July 2012, the Georgia Department of Public Health (GA DPH) was awarded the State Implementation Grant for System of Services for Children and Youth with Special Health Care Needs. This three year project focuses on improving the system of transition services for youth with special health care needs in Georgia for independence to adult health care, work, and education through collaboration with families, partner agencies and providers and improving access to coordinated on-going comprehensive care within a medical home.

The State Implementation grant has enabled partnerships between public and private agencies and organizations to address systemic barriers that result in families of children and youth with special needs not receiving transition services and accessing a medical home. Data from the 2010 Maternal and Child Health Block Grant Needs Assessment supports the need to improve

transition services and provider information through greater collaboration and integration of all community resources, as well as improve access for children and youth with special needs to receive services in a medical home.

The work cannot be done by agencies alone. Parents have the most comprehensive and accurate information about their children, and they are the experts. Based on this belief, they can become the child's best advocate when provided the tools and resources to do so. Because there are so many barriers to community living for children, youth and adults with disabilities and families lack access to necessary health supports, we must provide families' with additional information of health issues and build families' capacity to be decision-makers and influencers in their child's life.

Also, families are the subject matter experts regarding their experience in accessing a medical home and transition services. The input of youth and families with special health care needs, as well as parent support groups will be integrated into the grant activities by their active participation in all phases of the grant from planning to implementation and in the work of building sustainability strategies for after grant funding ends.

Section 2

Health Care Transition Planning Algorithm

The American Academy of Pediatrics published an algorithm to support health care transitions in the journal, *Pediatrics* Volume 128, Number 1, July 2011. This algorithm entitled, *The Health Care Transition Planning Algorithm for All Youth and Young Adults within a Medical Home Interaction* offers pediatricians a guide of the process of health care transitions for all youth from beginning to end. Pediatricians are encouraged to begin transition discussions once the child reaches age 12; other key ages are noted within the algorithm. Discussing transitions within well child exams that occur during the adolescent period helps to support youth transition readiness. Other opportunities for face-to-face communication include office visits to address acute illness or to manage on going health care needs. All discussions related to transitions should be documented in the child's medical record. The algorithm can be used as a decision making tool and provides specific questions whose answers create next steps in the process of youth transitions with the desired outcomes as the end goal.

The algorithm is a key component of the pediatric medical home's policy on transitions. This written policy should apply to all youth in the practice, be readily available, visible and "reflect the appropriate level of health literacy, reading and language proficiency, and cultural norms for the population the practice serves." It should also note that the goal of transition planning is essential to a healthy adult life. Resources such as web-based information, brochures, and posters can enhance the promotion of the offices' policy on transitions. In addition the article entitled, "*The Health Care Transition Planning Algorithm for All Youth and Young Adults within a Medical Home Interaction*" includes the following components of an office transition policy:

- **Reflect the appropriate level of health literacy, reading and language proficiency, and cultural norms for the population the practice serves**
- **Include the expected age of patient transfer to an adult model of health care;**
- **List the patient's responsibilities in preparing for transition;**
- **Identify the parent, family, and/or caregiver responsibilities in preparing for transition; and**
- **Specify the medical provider's responsibilities in preparing for transition.**

From this written policy, continuing the development of a written plan offers an ongoing assessment of the youth and parent's readiness for the healthcare transition, documents healthcare decisions for the receiving provider once the child reaches 18 to 21 years of age and can offer an opportunity to measure a quality improvement project for the medical home.

Additional resources to support this process include an Individualized Education Plan (IEP) which includes the discussion of an Individualized Transition Plan (ITP) which is required for those youth with a disability. This plan which is developed by a multidisciplinary team, parents and

the youth, can be developed for those 16 years or older as required by the Individuals with Disabilities Education Act. Youth attending colleges and universities that receive federal funding typically have an office that provides services to young adults with disabilities if the youth contacts them directly. Goals and timelines in an ITP differ slightly from those in an IEP. For example, goals can relate to self-care, employment, community living and post-secondary education.

Section 3

The Role of Medical Home and Transition

Expanding the Vision of the Medical Home

The term medical home has evolved and taken on added significance since its importance was first acknowledged by the American Academy of Pediatrics nearly four decades ago. It was defined at that time as a place where medical records are kept. Today it is more broadly defined as an approach to providing comprehensive primary care in a high quality and cost effective manner, in partnership with the family and patient to meet the medical and non-medical needs of infants, children and youth.

Pediatric and adult primary care providers often have an innate sense of the qualities of a medical home. Even sub-specialists often serve as medical homes for youth with complex and chronic conditions. There is agreement that medical home care exists along a continuum of care. Many providers have been using components of the medical home approach to regularly deliver care for years. The term medical home has been difficult to define and it has meant different things to different people. In addition, the epidemiology of chronic conditions in youth is characterized by a relatively large number of conditions affecting small subgroups. This makes it difficult to describe a “typical” subgroup for prescribing standards of care across a range of chronic conditions.

Fortunately, there have been recent efforts to better define the patient-centered medical home concept with the development of a 2007 statement by the AAFP, AAP, American College of Physicians, and American Osteopathic Society. *The Joint Principles of the Patient-Centered Medical Home* sets a high standard that requires commitments to policy, system, and practice level changes. “The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.”

The Patient Centered Primary Care Collaborative (PCPCC) has been key to promoting the patient-centered medical home and advocating for changes that are needed with legislators, businesses, purchasers, payers, health care providers, families, and others. This website is a valuable clearinghouse of information, resources, and activities across the country related to medical home and can be found at www.pcpcc.net.

Convergence of Medical Home and Transition

The 2002 Consensus Statement on Transition called for the medical profession to take the steps necessary to realize the vision of a “family centered, continuous, comprehensive, coordinated,

compassionate, and culturally competent health care system that is as developmentally appropriate as it is technically sophisticated". The statement illustrates how the elements of the medical home approach support a successful transition process from pediatric to adult health care. The concept of medical home clearly converges with recommendations for transition care for youth with special needs. A medical home is even more important for those with a chronic condition. This is especially true for YSHCN as they move from what has been a nurturing, parent driven health care system of care to an adult oriented system of care that is more unfamiliar, and requires a new degree of independence and responsibility.

The National Committee for Quality Assurance (NCQA) has recently worked with the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA) and others in order to create a set of standards to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the Physician Practice Connections – Patient Centered Medical Home (PPC®-PCMHTM) standards emphasize the use of systematic, patient-centered, coordinated care management processes. There are nine PPC® standards, including ten must-pass elements (which can result in one of three levels of recognition): access and communication; patient tracking and registry functions; care management; patient self-management support; electronic prescribing; test tracking; referral tracking; performance reporting and improvement; and advanced electronic communication. Practices seeking PPC®-PCMHTM recognition complete a web-based data collection tool and provide documentation that validates responses. Several states are using the NCQA medical home standards to pilot medical home demonstration projects that are linked to enhanced reimbursement depending on the level of recognition that is met by the practice.

Prior to the release of the NCQA toolkit, the Center for Medical Home Improvement (CMHI) developed practice self-assessment survey tools to help with quality improvement in evaluating how well a practice is doing and where their score places them on the medical home continuum. The survey is directed toward primary care pediatricians, but it is also applicable for pediatric sub-specialists and adult providers. This information may be found at http://www.medicalhomeimprovement.org/assets/pdf/MHI-ShortV_2006CMHI.pdf.

The Family Medical Home Index (also from CMHI) has been another valuable tool to evaluate the delivery of medical home care for several years.
(See <http://www.medicalhomeimprovement.org/assets/pdf/MHIK-tools.pdf>.)

The National Institute for Family Centered Care developed several tools and resources for providers on how to partner with patients and families.

Providers are encouraged to implement the NCQA standards of access, communication, registry and patient tracking functions, care management and patient self-management support that are embedded within the medical home model to assure successful transition.

The focus of care must move beyond acute illness management to comprehensive care of the youth in the context of their home and community. This requires close collaboration between primary care, subspecialty, public health, mental health, oral health, adult providers, and ancillary providers with community health and human services programs committed to serving the needs of youth with special health care needs.

Health care providers can join or build a transition team composed of multiple agencies and individuals capable of:

- Assessing an individual's and family's knowledge, resources and abilities;
- Coordinating and communicating about information and resources; and
- Developing action steps to overcome barriers and facilitate transitioning in all aspects of the youth's life.

Well-defined and coordinated action steps must be developed to address the transition needs that exist within the context of the family and within the health care, educational, and vocational systems. For youth with special needs who anticipate a future physical transfer of care from a pediatric to an adult medical home, there are additional issues to consider. The adult health care provider should be a member of the transition team as the youth gets closer to the planning for the physical transfer.

The patient-centered medical home concept promotes good transition care and emphasizes the coordination of services. It is also consistent with the principles of chronic care management which also apply to transition care:

- The use of defined plans and protocols;
- Practice systems designed to meet the needs of individual patients (more time, broader array of services, and closer follow-up);
- Systematic attention to meeting patient education needs and behaviors;
- Ready access to necessary expertise; and
- Effective information systems.

Health Care Provider Recommendations from the AAP Clinical Report—Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home

All pediatricians should ensure through collaboration with local schools that their patients with disabilities or chronic illnesses have access to the following:

1. A medical home that promotes accessible, continuous, comprehensive, family-centered, coordinated, and compassionate care. To be most effective, the medical home must play a role in the partnership among the family, teenager, and other community health and human services professionals.

2. Assessment of child's strengths and abilities, not only disabilities. Students must understand and appreciate their abilities, interests, and values. They need to have high self-esteem, know their career options, and be able to make good decisions. To make all this happen, the transition process must be ongoing and embedded in the curriculum in the students' early years with career exploration and progressing through IEP/transition planning.
3. Federal law mandates that transition planning begin at age 14. At age 16, needed transition services should be included in the IEP. Encourage the family to actively participate in IEP/transition planning.
4. Printed information about the provisions in IDEA designed to promote the identification and achievement of appropriate transition outcomes and names and telephone numbers of community-based resources to help families fully understand and maximize the potential of the process for their child. Someone knowledgeable about legal rights of persons with disabilities should review entitlements with the family and teenager, including Supplemental Security Income and Medicaid.
5. An opportunity with parental and adolescent consent for sharing pertinent medical information with the IEP team. The pediatrician should explain the modifications that may be necessary based on the student's personal medical history.
6. Enrollment as early as possible in the state's rehabilitation counseling services.
7. Opportunities to explore a variety of careers through part-time jobs, volunteer work, or guidance with mentors.
8. Transfer by the family to the teen opportunities to take responsibility for self-care, budgeting of weekly allowance, and household and yard chores consistent with physical and mental abilities.
9. Contact with successful young adult role models.
10. Attendant care services, if needed, while the teenager is still living at home. Allow the teenager to interview prospective attendants and then to select, hire, and supervise the employee with parental input if the teenager is still a minor.
11. A resource list of local independent living arrangements. Support the enrollment of the teenager in an independent living skills course as soon as age requirements are met.
12. An experienced family counselor who can assist the parents and teenager in defining boundaries and responsibilities if substantial parent-teenager conflict exists.

13. Meaningful employment opportunities in the community and vocational education that challenges the student and prepares the student for the 21st century.
14. A primary clinician who is a good listener for open discussion of the teenager's career goals and concerns.

Section 4

Transition and Reimbursement

The following charts were prepared by the National Academy of Pediatrics for the Illinois Chapter of the American Academy of Pediatrics and outlines codes used to report preventative health services and non face-to face services to support transition planning:

Additional information at http://www.medicalhomeinfo.org/how/payment_and_finance/#coding.

Preventive Medicine Services (Established Patients): 99393-99395*

These codes are used to bill for preventive medicine services, based on age, including comprehensive history/exam, anticipatory guidance/counseling, and labs/diagnostics. (* Medicaid covered services)

Code	Description - Age	Example
99393*	Late childhood/ Age 5-11	Amy, a 19-year-old with JRA, comes in for an annual physical exam prior to college and presents with a decubitus ulcer. Document the anticipatory guidance counseling for the preventive visit, including wheelchair seating maintenance, daily skin checks, health insurance options for adults, transition policy discussion and emergency plan, along with the examination and documentation for the pressure sore. Bill 99395 for the preventive physical exam visit and 99214-25 for the additional decubitus ulcer problem.
99394*	Adolescent/ Age 12-17	
99395*	Adult/ Age 18-39	

Team Conferences: 99367-99368

Use for team conference of 30 or more minutes involving physician or non-physician staff and other health professionals/community agency staff (patient/family not present)

Code	Description	Example
99367	Involving physician	Paul has cystic fibrosis (ICD-9 277.00) and pneumonia (ICD-9 513.0). You attend the IEP/Transition Plan meeting at the school. You discuss transition goals to increase independence in health care management with the school nurse and CF clinic coordinator. During the 40-minute meeting, you make specific treatment recommendations and document this in the record and bill 99367 .
99368	Involving non-physician staff	

Materials supported through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, D70MC12840. Developed by the UIC - Division of Specialized Care for Children and the Illinois Chapter, American Academy of Pediatrics. 7/11

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Prolonged Services - Non-face-to-face Services

Use for non-face-to-face transition planning when neither the patient nor family are present. Examples include portable medical summary oversight, review of reports and lab results, research, and family and provider discussions by phone or correspondence.

Do not double report using both sets of codes described here.

Code	Description/Time	Example
99358	E/M before and/or after patient care; first 60 minutes	Jenny, 16 years old, has diagnoses of spina bifida with hydrocephalus (ICD-9 741.0), neurogenic bladder (ICD-9 596.54), decubitus (ICD-9 707.03), scoliosis (ICD-9 737.30), and hydronephrosis (ICD-9 591.0). Jenny presented for an E/M visit (99214) to evaluate and address her decubitus ulcer and neurogenic bladder issues. Code 99358 and 99359 (E/M before and/or after patient care) was used and reported with pertinent ICD-9 codes to substantiate the need for care coordination and complex care planning. Following the patient visit, the physician documented and spent 90 minutes on review of health care skills checklist, discussion with the wound care center, review of a cystogram, and follow-up and collaboration with the spina bifida nurse coordinator about self-catheterization compliance and ways to promote health care self-management skills.
99359	E/M before and/or after patient care; each additional 30 minutes (list separately in addition to code 99358)	

NOTE: 99358-99359 must be reported on the same date of service.

Code	Description/Time	Example
99339	Care plan oversight/monthly supervision; 15-29 minutes	Johnny, 17 years old, has diagnoses of infantile cerebral palsy (ICD-9 343.9), GE reflux (ICD9- 530.81), ankle foot joint contracture (ICD-9 718.4-7), seizures (ICD-9 345), and dysphagia (ICD-9 787.20). Physician supervision and care plan oversight activities for 45 minutes to develop a portable medical summary; review a power mobility evaluation report; review his swallow test results; and identify and talk with 4 potential adult PCPs to determine willingness, ability, and fit for assuming Johnny's adult health care are billed as 99340 .
99340	Care plan oversight/monthly supervision; 30 minutes or more	

NOTE: 99339-99340 are reported once per 30 days

Prolonged Services – Face-to-Face: 99354-99355*

For billing based on time spent with the patient/family, reported in addition to the E/M code for the level of visit. These codes support the time and effort involved in care coordination and complex care planning. Include ALL pertinent ICD-9 codes in the documentation - not just the ICD-9 codes related to the reason for the visit that day. (* Medicaid covered services).

Code	Description/Time	Example
99354*	Outpatient face-to-face; first 60 minutes	An 18-year-old with Asperger syndrome (ICD-9 299.8) is seen for mood swings. Additional time is spent identifying mental health counseling community resources, discussing the <i>Guide to Adult Benefits, Services, and Resources</i> , and reviewing medication management. The 75-minute visit is prolonged beyond the typical time of 45 minutes listed for E/M code 99215 . Bill 99215 and 99354 for the extra 30 minutes spent addressing and documenting the health problems.
99355*	Outpatient face-to-face; each additional 30 minutes – add on to 99354	

Office Procedures to support proper coding

1. Conduct periodic coding sessions for staff to ensure understanding of correct codes.
2. Update encounter forms to include CPT and ICD-9 codes that reflect the patient population and to help staff use and document appropriate codes.
3. Design progress note templates to help document services.
4. Review billing data/reports to assess your coding practices and trends.
5. Realize that codes may not be reimbursed by all payers or in all cases -- for example: 99339/99340 (care plan oversight over 30 days) and 99214/99215 (E/M of moderate/high severity, 25-40minutes).
6. Have policies in place for denied claims and family payment expectations.
7. Consider tracking which insurance carriers reimburse for which codes.

Resources

- The AAP [Medical Home Coding Fact Sheet](#) highlights commonly reported codes for medical homes and is updated annually to provide current coding information.
- The AAP [Coding Hotline](#), available with membership or a subscription to the AAP Coding Newsletter Online.
- DSCC [Reimbursement Guidelines for Medical Home Services](#)
- Illinois Chapter, American Academy of Pediatrics
<http://illinoisAAP.org/projects/transition/>

Coding and Reimbursement Tips

1. **Utilize higher intensity E/M codes** – use **99214 - 99215** for acute problems or chronic condition follow-up supported with documentation.
2. **Document all medical decision-making or care coordination** services, including phone calls, correspondence, and complex care planning. Include ALL pertinent ICD-9 codes in the documentation - not just the ICD-9 codes related to the reason for the visit that day.
3. **Document time** spent, including phone conferences with the patient/family, specialists, and other providers. **Bundle time into the face-to-face visit** (bundling time may not exceed 1 month lapse from service date) or report separately if appropriate.
4. **Become a DSCC medical home provider.** In Illinois, the UIC Division of Specialized Care for Children will reimburse for care coordination activities that involve the management and development of care plans for DSCC-enrolled children and youth with special health care needs.

Evaluation & Management (Established Patients): 99211-99215*

These codes are used to bill for physician evaluation and management (E/M) services for established patients and/or families seen in a face-to-face or other outpatient visit. There are similar codes for New Patients: 99201-99205. (* Medicaid covered services)

Code	Description Severity/Time	Example
99211*	None/ 5 minutes (Nurse Visits)	A 17-year-old established patient with Down Syndrome (ICD-9 759.81), aphasia (ICD-9 315.31), VSD (ICD-9 754.4), and hearing loss (ICD-9 389.08) is seen for a routine visit. The 25-minute visit is spent counseling the patient/parents on healthy eating habits, exercise, and discussing guardianship. After the patient leaves, 40 minutes is spent on telephone calls to the dietitian, school nurse, and DSCC care coordinator to discuss diet and identify resources for fitness programs. Bill 99214 and 99358 for the extra 40 minutes spent addressing and documenting the patient's health problems.
99212*	Straightforward/ 10 minutes	
99213*	Low severity/ 15 minutes	
99214*	Moderate severity/ 25 minutes	
99215*	High severity/ 40 minutes	

Modifier -25 may be added for significant, separately identifiable E/M services, and is frequently used for time spent on patients with special health care needs. (See Preventive Medicine Services example.)

Coding and Reimbursement Tip Sheet for Health Care Transition

Prepared by Got Transition and the American Academy of Pediatrics

“updated version of the coding and reimbursement tip sheet will be available in early 2015 on www.gottransition.org”

Transition Related Services		100% Medicare Payment	
CPT Code	Code Description	Office	Facility
Office Or Other Outpatient Services, New Patient			
99201	Self- limited or minor problem, 10 min.	\$43.89	\$25.86
99202	Low to moderate severity problem, 20 min.	\$74.51	\$48.99
99203	Moderate severity problem, 30 min.	\$107.85	\$74.85
99204	Moderate to high severity problem, 45 min.	\$164.67	\$127.93
99205	High severity problem, 60 min.	\$203.80	\$164.33
Office Or Other Outpatient Services, Established Patient			
99211	Minimal presenting problems, 5 min.	\$20.41	\$8.85
99212	Self-limited or minor problem, 10 min.	\$43.89	\$24.50
99213	Low to moderate severity problem, 15 min.	\$72.47	\$49.67
99214	Moderate severity problem, 25 min.	\$106.49	\$76.55
99215	Moderate to high severity problem, 40 min.	\$142.90	\$107.85
Prolonged Physician Services			
99354	Prolonged physician services, in office or other outpatient setting, with direct contact; first hour (use in conjunction with time-based codes 99201-99215, 99241-99245, 99301-99350)	\$97.31	\$89.82
99355	Each additional 30 min. (use in conjunction with 99354)	\$94.92	\$87.44
99358	Prolonged physician services without direct patient contact; first hour		
99359	For each additional 30 min. (use in conjunction with 99358)		
Office Or Other Outpatient Consultations			
99241	New or established patient; self limited or minor problem, 15 min.	\$46.61	\$32.32
99242	Low severity problem, 30 min.	\$87.78	\$67.71
99243	Moderate severity problem, 45 min.	\$119.76	\$94.24
99244	Moderate to high severity problem, 60 min.	\$176.92	\$149.02
99245	Moderate to high severity problem, 80 min.	\$216.39	\$185.09
Preventive Medicine Service			
99384	Initial comprehensive preventive medicine, new patient; ages 12-17	\$134.39	\$100.03
99394	Periodic comprehensive preventive medicine, established patient; ages 12-17	\$114.66	\$84.72

Medical Team Conference¹			
99366	With interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by non-physician qualified health care professional		
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician		\$54.78
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional		
Care Plan Oversight Services²			
99339	Individual physician supervision of a patient in home requiring complex and multidisciplinary care modalities involving regular physician development or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s), or key caregiver(s) involved in patient's care; integration of new information into medical treatment plan; or adjustment of medical therapy; within a calendar month; 15 to 29 minutes	\$75.87	
99340	For 30 minutes or more	\$106.15	
Complex Chronic Care Coordination³			
99487	First hour of clinical staff time directed by a physician or other quality health care professional with no face-to-face visit	\$82.00	
99488	First hour of clinical staff time directed by a physician or other quality health care professional with one face-to-face visit	\$183.72	
99489	Each additional 30 minutes of clinical staff time directed by a physician or other quality health care professional	\$41.17	
Transitional Care Management⁴			
99495	Includes communication (direct contact, telephone, electronic) with patient /caregiver in 2 business days of discharge; medical decision making of at least moderate complexity during service period; and face-to-face visit, in 14 calendar days of discharge	\$163.99	\$134.73
99496	Includes communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of high complexity during the service period; and face-to-face visit, within 7 calendar days of discharge	\$231.02	\$197.67
Education & Training for Patient Self-Management⁵			

98960	Education and training of patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	\$28.92	
98961	2-4 patients	\$13.95	
98962	5-8 patients	\$10.21	
Physician Educational Services			
99078	Rendered to patients in a group setting (eg, obesity or diabetic instructions)		
Health & Behavior Assessment/Intervention⁶			
96150	Health and behavior assessment, each 15 minutes face-to-face with the patient; initial assessment	\$20.07	\$19.73
96151	Re-assessment	\$19.39	\$19.05
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	\$18.37	\$18.03
96153	For a group (2 or more patients)	\$4.42	\$4.08
96154	For a family (with the patient present)	\$18.03	\$17.69
96155	For a family (without the patient present)	\$22.11	\$22.11
Counseling Risk Factor Reduction & Behavior Change Intervention⁷			
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	\$36.06	\$23.82
99402	Approximately 30 minutes	\$61.24	\$49.33
99403	Approximately 45 minutes	\$85.06	\$73.15
99404	Approximately 60 minutes	\$109.21	\$97.31
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	\$13.61	\$11.91
99407	Intensive, greater than 10 minutes	\$26.88	\$24.84
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	\$34.36	\$32.32
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes		
99412	Approximately 60 minutes		
Physician Telephone Evaluation/Management Services⁸			
99441	Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical	\$13.61	\$12.25

	discussion		
99442	11-20 minutes of medical discussion	\$26.20	\$24.84
99443	21-30 minutes of medical discussion	\$38.79	\$37.43
Basic Life and/or Disability Evaluation Services			
99450	Includes measurement of height, weight, and blood pressure, completion of a medical history following a life insurance pro forma, collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and completion of necessary documentation/certificates		
99455	Work related or medical disability evaluation services that include completion of medical history commensurate with patient's condition; performance of examination commensurate with patient's condition; formulation of diagnosis; assess of capabilities and stability and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report		

CPT Description of Selected Codes

1. **Medical team conferences** (CPT Codes 99366 – 99368) include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (eg, legal guardian), and/or caregiver(s). The participants are actively involved in the development, revision, coordination, and implementation of health care service needed by the patient. Reporting participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days.
2. **Care plan oversight services** (CPT Codes 99339 – 99340) are reported separately from Codes 99374-99380, which refer to care plan oversight services for patients under the care of a home health agency, hospice, or nursing facility.
3. **Complex chronic care coordination services** (CPT Codes 99487 – 99489) are patient-centered management and support services provided by physicians, other qualified health care professionals, and clinical staff to an individual who resides at home or in a domiciliary, rest home, or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional. These services address the coordination of care by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

Patients who require complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (eg, predictive modeling risk score or repeat admissions or emergency department use) or by clinician judgment. Typical patients have 1 or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. Patients may have medical and psychiatric behavioral co-morbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support weaknesses or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are expected. Medical decision making as defined in the Evaluation and Management (E/M) guidelines is not only applied to the face-to-face services but is determined by the nature of the problems addressed by the reporting individual during the month. A plan of care should be documented and shared with the patient and/or caregiver.

Codes 99487 – 99489 are reported only **once** per calendar month and include all non-face-to-face complex chronic care coordination services and none or 1 face-to-face office or other outpatient, home, or domiciliary visit. Codes 99487–99489 may only be reported by the single physician or other qualified health care professional who assumes the care coordination role with a particular patient for the calendar month.

Code selection is as follows:

Code 99487 is reported when, during the calendar month, there is no face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities. Code 99488 is reported when, during the calendar month, there is a face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities.

The face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals and agencies; revising, documenting and implementing the care plan; or teaching self-management is used in determining the complex chronic care coordination clinical staff time for the month. Note: Do not count any clinical staff time on the date of the first visit or on a day when the physician or other qualified health professional reports an E/M service (office or other outpatient services 99211 –99215; domiciliary; rest home services 99334–99337; home services 99347–99350).

Care coordination activities performed by clinical staff may include:

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professional) regarding aspects of care;

- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caretaker education to support self-management, independent living,
- and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- development and maintenance of a comprehensive care plan

If a face-to-face visit was provided during the month by the physician or other qualified health care professional, report 99488. Additional E/M services beyond the first visit may be reported separately by the same physician or other qualified health care professional during the same month. Complex care coordination services include care plan oversight (99339, 99340, 99374 – 99378), prolonged service without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366 – 99368), education and training (98960-98962, 99071, 99078), telephone (98966-98968, 99441 – 99443), online medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), transitional care management (99495, 99496), medication therapy management (99605 – 99607), and if performed, these service may not be reported separately during the month for which 99487-99489 are reported. All other services may be reported. Do not report 99487 – 99489 if reporting ESRD services (90951 – 90970) during the same month. If the complex chronic care coordination services are performed within the postoperative period of a reported surgery, the same individual may not report 99487 – 99489.

Complex chronic care coordination can be reported in any calendar month during which the clinical staff time requirements are met. If care coordination resumes after a discharge during a new month, start a new period or report transitional care management services (99495-99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report transitional care management services. Do not report 99487–99489 for an post-discharge complex chronic care coordination services for any days within 30 days of discharge, if reporting 99495, 99496.

4. **Transition care management services** (CPT Codes 99495 – 99496) are used to report transitional care management services (TCM). These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient’s community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continued for the next 29 days.

TCM is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care professional may include:

- obtaining and reviewing the discharge information (eg, discharge summary, as available, or continuity of care documents);
- reviewing need for or follow-up on pending diagnostic tests and treatments;
- interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
- education of patient, family, guardian, and/or caregiver;
- establishment or reestablishment of referrals and arranging for needed community services
- assistance in scheduling any required follow-up with community providers and services.

TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic, or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit.

These services address any needed coordination of care performed by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact and continuous success.

Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. For 99496, the face-to-face visit must occur within 7 calendar days of the date of discharge, and medical decision making must be of high complexity. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge, and medical decision making must be of at least moderate complexity.

5. **Education and training services** (CPT Codes 98960 – 98962) teach the patient (may include caregiver[2]) how to effectively self-manage the patient's illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient's professional healthcare team. Education and training related to subsequent reinforcement or due to changes in the patient's condition or treatment plan are reported in the same manner as the original education and training. The type of education and training provided for the patient's clinical condition will be identified by the appropriate diagnosis code(s) reported.

The qualifications of the nonphysician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, nonphysician healthcare professional society/association, or other appropriate source.

Note: Education and training for patient self-management may be reported with these codes only when using a standardized curriculum as described above. The curriculum may be modified as necessary for the clinical needs, cultural norms and health literacy of the individual patient(s).

6. **Health and behavior assessment procedures** (CPT Codes 96150 – 96155) are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.

The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments. The focus of the intervention is to improve the patient's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

Codes 96150 – 96155 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions.

7. **Counseling risk factor reduction and behavior change intervention** (CPT Codes 99401 – 99408) are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from evaluation and management (E/M) services that may be reported separately when

performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.

Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.

Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.

8. **Physician telephone evaluation/management services** (CPT Codes 99441 – 99443) are non face-to-face E/M services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see that patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service, procedure, and visit. Likewise if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure.

Appendices

The following pages include resources and forms to assist in supporting your adolescent patients to adult primary care.

Appendix A: Center for Health Care Transition Improvement, *Six Core Elements of Health Care Transition 2.0 Tool Overview:*

Health Care Transition - Implement It

Got Transition supports practices in the implementation and evaluation of transition quality improvement through the Six Core Elements of Health Care Transition 2.0. Comprehensive tool packages are available for three transition processes: 1) transitioning youth to adult health care providers, 2) transitioning youth to an adult approach to health care without changing providers and 3) integrating youth into adult health care. These packages include sample policies, registries, transition readiness/self-care assessments, condition fact sheets, medical summary and emergency care plans, transfer letters and checklists, young adult orientation material, care plans, feedback surveys and measurement approaches.

Appendix B: Six Core Elements of Health Care Transition 2.0 Sample Clinical Tools

- Sample Transition Policy
- Six Core Elements of Health Care Transition
- Sample Transition Readiness Assessment for Youth
- Sample Transition Readiness Assessment for Parents/Caregivers
- Sample Medical Summary and Emergency Care Plan
- Sample Transfer of Care Checklist
- Sample Transfer Letter

Appendix C: Health Care Transition Planning Algorithm for all Youth and Young Adults within a Medical Home Interaction from the American Academy of Pediatrics: This flow chart is a resource which outlines the process of youth transitions of adult care.

Appendix D: Georgia Family Fact Sheets

Appendix E: Online Resources

Appendix F: References

Appendix A: Six Core Elements of Health Care Transition 2.0 Overview

1. Transition Policy

- Develop a transition policy/statement with input from youth and families that describes the practice's approach to transition, including privacy and consent information.
- Educate all staff about the practice's approach to transition, the policy/statement, the *Six Core Elements*, and distinct roles of the youth, family, and pediatric and adult health care team in the transition process, taking into account cultural preferences.
- Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care.

2. Transition Tracking and Monitoring

- Establish criteria and process for identifying transitioning youth and enter their data into a registry.
- Utilize individual flow sheet or registry to track youth's transition progress with the *Six Core Elements*.
- Incorporate *Six Core Elements* into clinical care process, using EHR if possible.

3. Transition Readiness

- Conduct regular transition readiness assessments, beginning at age 14, to identify and discuss with youth and parent/caregiver their needs and goals in self-care.
- Jointly develop goals and prioritized actions with youth and parent/caregiver and document regularly in a plan of care.

4. Transition Planning

- Develop and regularly update the plan of care, including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents.
- Prepare youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information.
- Determine need for decision-making supports for youth with intellectual challenges and make referrals to legal resources.
- Plan with youth and parent/caregiver for optimal timing of transfer. If both primary and subspecialty care are involved, discuss optimal timing for each.
- Obtain consent from youth/guardian for release of medical information.
- Assist youth in identifying an adult provider and communicate with selected provider about pending transfer of care.
- Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.

5. Transfer of Care

- Confirm date of first adult provider appointment.
- Transfer young adult when his/her condition is stable.
- Complete transfer package, including final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional provider records.
- Prepare letter with transfer package, send to adult practice, and confirm adult practice's receipt of transfer package.
- Confirm with adult provider the pediatric provider's responsibility for care until young adult is seen in adult setting.

6. Transfer Completion

- Contact young adult and parent/caregiver 3 to 6 months after last pediatric visit to confirm transfer of responsibilities to adult practice and elicit feedback on experience with transition process.
- Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed.
- Build ongoing and collaborative partnerships with adult primary and specialty care providers.

Appendix B: Six Core Elements of Health Care Transition 2.0 Sample Clinical Tools

Sample:

- **Transition Policy**
- **Transition Readiness Assessment for Youth**
- **Transition Readiness Assessment for Parents/Caregivers**
- **Medical Summary and Emergency Care Plan**
- **Transfer of Care Checklist**
- **Transfer Letter**

“Declaring” a Health Care Transition (HCT) Policy for Your Practice Young Adult Privacy and Consent

The first step to health care transition improvement will be to articulate a practice “HCT Policy” and share it with your patients and families. This “policy” should include and /or address the following:

- A practice wide consistent approach to health care transition
- Be readable (literacy levels/languages), and accessible in print
- Describe HCT as a positive part of lifelong preparation for a successful and well adult life
- Share how HCT support facilitates timely movement from pediatric to adult care

Your HCT policy should also be:

- A part of all primary care practice introductory materials;
- It should be visibly posted for all patients and families to see and read, and
- Will need to be “reintroduced” to youth and families at or around the age of 12 and beyond.

Every practice is unique and will want to communicate their HCT policy and practices in their own way. The following is an example to help get you started with the writing of your own HCT Policy.

[Pediatric Practice Name] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a “pediatric” model of care where parents make most decisions to an “adult” model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult’s consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.



Sample Transition Readiness Assessment for Youth

Please fill out this form to help us see what you already know about your health and how to use health care and the areas that you need to learn more about. If you need help completing this form, please ask your parent/caregiver.

Date:

Name:

Date of Birth:

Transition Importance and Confidence *On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

How important is it to you to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9
---------	---	---	---	---	---	---	---	---	---

How confident do you feel about your ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9
---------	---	---	---	---	---	---	---	---	---

My Health	<i>Please check the box that applies to you right now.</i>	Yes, I know this	I need to learn	Someone needs to do this... Who?
I know my medical needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I can explain my medical needs to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know my symptoms including ones that I quickly need to see a doctor for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know what to do in case I have a medical emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know my own medicines, what they are for, and when I need to take them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know my allergies to medicines and medicines I should not take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I understand how health care privacy changes at age 18 when legally an adult.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Using Health Care				
I know or I can find my doctor's phone number.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I make my own doctor appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Before a visit, I think about questions to ask.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I have a way to get to my doctor's office.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know to show up 15 minutes before the visit to check in.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know where to go to get medical care when the doctor's office is closed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I have a file at home for my medical information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I have a copy of my current plan of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know how to fill out medical forms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know how to get referrals to other providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know where my pharmacy is and how to refill my medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I know where to get blood work or x-rays if my doctor orders them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I have a plan so I can keep my health insurance after 18 or older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
My family and I have discussed my ability to make my own health care decisions at age 18.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Sample Transition Readiness Assessment for Parents/Caregivers

Please fill out this form to help us see what your child already knows about his or her health and the areas that you think he/she needs to learn more about. After you complete the form, compare your answers with the form your child has complete. Your answers may be different. We will help you work on some steps to increase your child's health care skills.

Date:

Name:

Date of Birth:

Transition Importance and Confidence *On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

How important is it for your child to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9
---------	---	---	---	---	---	---	---	---	---

How confident do you feel about your child's ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9
---------	---	---	---	---	---	---	---	---	---

My Health	<i>Please check the box that applies to your child right now.</i>	Yes, he/she knows this	He/she needs to learn	Someone needs to do this... Who?
My child knows his/her medical needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child can explain his/her medical needs to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows his/her symptoms including ones that he/she quickly needs to see a doctor for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows what to do in case he/she has a medical emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows his/her own medicines, what they are for, and when he/she needs to take them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows his/her allergies to medicines and medicines he/she should not take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child carries important health information with him/her every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows he/she can see a doctor alone as I wait in the waiting room.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child understands how health care privacy changes at age 18.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child can explain to others how his/her customs and beliefs affect health care decisions and medical treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Health Care				
My child knows or can find his/her doctor's phone number.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child makes his/her own doctor appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Before a visit, my child thinks about questions to ask.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has a way to get to his/her doctor's office.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows to show up 15 minutes before the visit to check in.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows where to go to get medical care when the doctor's office is closed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has a file at home for his/her medical information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has a copy of his/her current plan of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows how to fill out medical forms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows how to get referrals to other providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows where his/her pharmacy is and how to refill his/her medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows where to get blood work or x-rays if his/her doctor orders them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has a plan to keep his/her health insurance after ages 18 or older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child and I have discussed his/her ability to make his/her own health care decisions at age 18.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child and I have discussed a plan for supported decision-making, if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Sample Medical Summary and Emergency Care Plan

This document should be shared with and carried by youth and families/caregivers.		
Date Completed:		Date Revised:
Form completed by:		
Contact Information		
Name:		Nickname:
DOB:		Preferred Language:
Parent (Caregiver):		Relationship:
Address:		
Cell #:	Home #:	Best Time to Reach:
E-Mail:		Best Way to Reach: Text Phone Email
Health Insurance/Plan:		Group and ID #:
Emergency Care Plan		
Emergency Contact:		Relationship:
Preferred Emergency Care Location:		Phone:
Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations
Special Concerns for Disaster:		
Allergies and Procedures to be Avoided		
Allergies	Reactions	
To be avoided	Why?	
<input type="checkbox"/> Medical Procedures:		
<input type="checkbox"/> Medications:		
Diagnoses and Current Problems		
Problem	Details and Recommendations	
<input type="checkbox"/> Primary Diagnosis		
<input type="checkbox"/> Secondary Diagnosis		
<input type="checkbox"/> Behavioral		
<input type="checkbox"/> Communication		
<input type="checkbox"/> Feed & Swallowing		
<input type="checkbox"/> Hearing/Vision		
<input type="checkbox"/> Learning		
<input type="checkbox"/> Orthopedic/Musculoskeletal		
<input type="checkbox"/> Physical Anomalies		
<input type="checkbox"/> Respiratory		
<input type="checkbox"/> Sensory		

<input type="checkbox"/> Stamina/Fatigue					
<input type="checkbox"/> Other					
Medications					
Medications	Dose	Frequency	Medications	Dose	Frequency
Health Care Providers					
Provider	Primary and Specialty	Clinic or Hospital	Phone	Fax	
Prior Surgeries, Procedures, and Hospitalizations					
Date					
Date					
Date					
Date					
Date					
Baseline					
Baseline Vital Signs:	Ht	Wt	RR	HR	BP
Baseline Neurological Status:					
Most Recent Labs and Radiology					
Test	Date	Result			
EEG					
EKG					
X-Ray					
C-Spine					
MRI/CT					
Other					
Other					
Equipment, Appliances, and Assistive Technology					
<input type="checkbox"/> Gastrostomy	<input type="checkbox"/> Adaptive Seating		<input type="checkbox"/> Wheelchair		
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Communication Device		<input type="checkbox"/> Orthotics		

<input type="checkbox"/> Suctions	Monitors:	<input type="checkbox"/> Crutches
<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Apnea <input type="checkbox"/> Cardiac	<input type="checkbox"/> O2 <input type="checkbox"/> Walker <input type="checkbox"/> Glucose
<input type="checkbox"/> Other		
School and Community Information		
Agency/School	Contact Information	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:
Special information that the youth or family wants health care professionals to know		

_____ Youth signature	_____ Print Name	_____ Phone Number	_____ Date
--------------------------	---------------------	-----------------------	---------------

_____ Parent/Caregiver	_____ Print Name	_____ Phone Number	_____ Date
---------------------------	---------------------	-----------------------	---------------

_____ Primary Care Provider Signature	_____ Print Name	_____ Phone Number	_____ Date
--	---------------------	-----------------------	---------------

_____ Care Coordinator Signature	_____ Print Name	_____ Phone Number	_____ Date
-------------------------------------	---------------------	-----------------------	---------------

Please attach the immunization record to this form.



Sample Transfer of Care Checklist

Patient Name: _____

Date of Birth: _____

Primary Diagnosis: _____

Transition Complexity: _____
Low, moderate, or high

-Prepared transfer package including:

- ☐ Transfer letter, including effective of date of transfer of care to adult provider
- ☐ Final transition readiness assessment
- ☐ Plan of care, including transition goals and pending actions
- ☐ Updated medical summary and emergency care plan
- ☐ Guardianship or health proxy documents, if needed
- ☐ Condition fact sheet, if needed
- ☐ Additional provider records, if needed

-Sent transfer package _____
Date

-Communicated with adult provider about transfer _____
Date



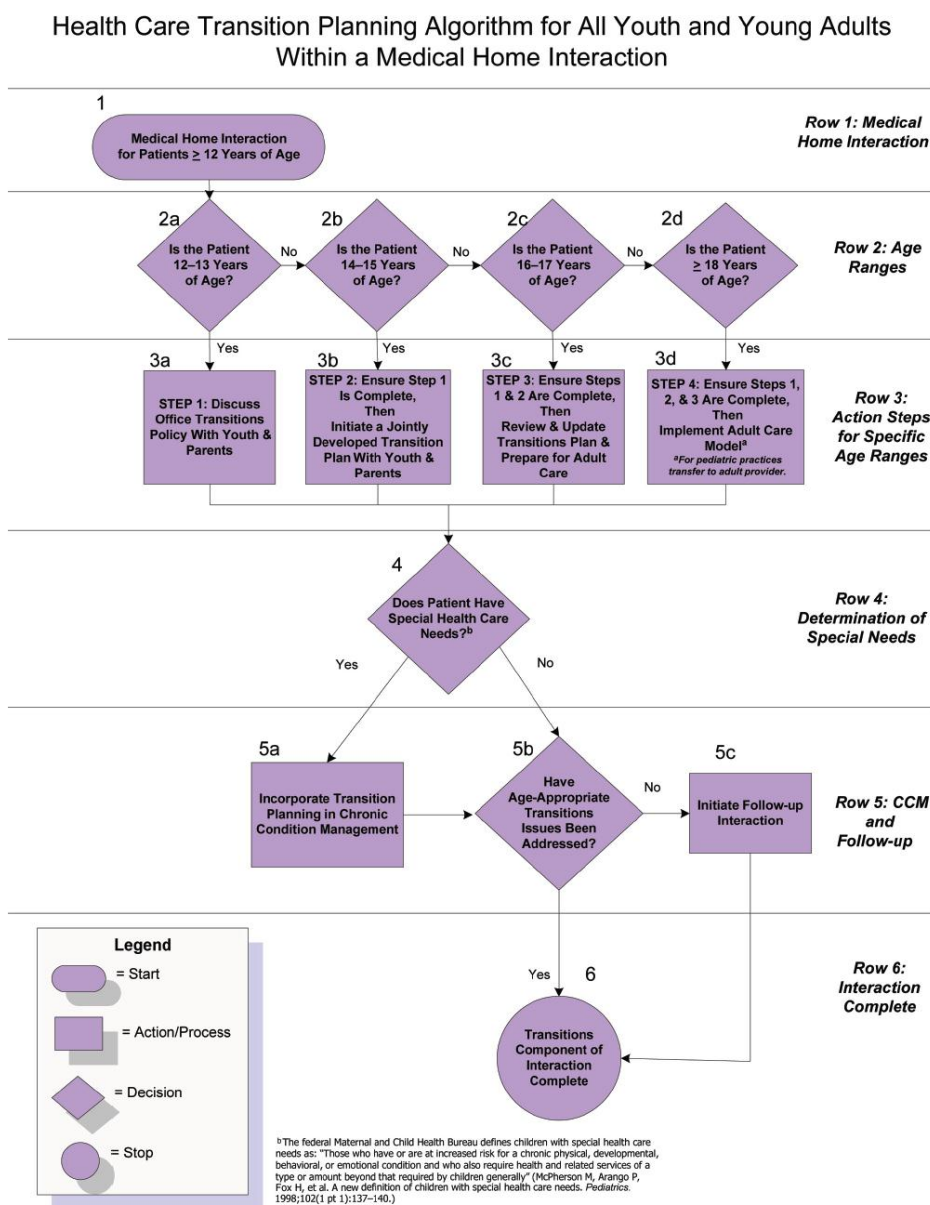
Dear Adult Provider,

Name is an age year-old patient of our pediatric practice who will be transferring to your care on date of this year. His or her primary chronic condition is condition, and his or her secondary conditions are conditions. Name's related medications and specialists are outlined in the enclosed transfer package that includes his or her medical summary and emergency care plan, plan of care, and transition readiness assessment. Name acts as his or her own guardian, and is insured under insurance plan until age age. I have had name as a patient since age and am very familiar with his or her health condition, medical history, and specialists. I would be happy to provide any consultation assistance to you during the initial phases of name's transition to adult health care. Please do not hesitate to contact me by phone or email if you have further questions. Thank you very much for your willingness to assume the care of this young man or woman.

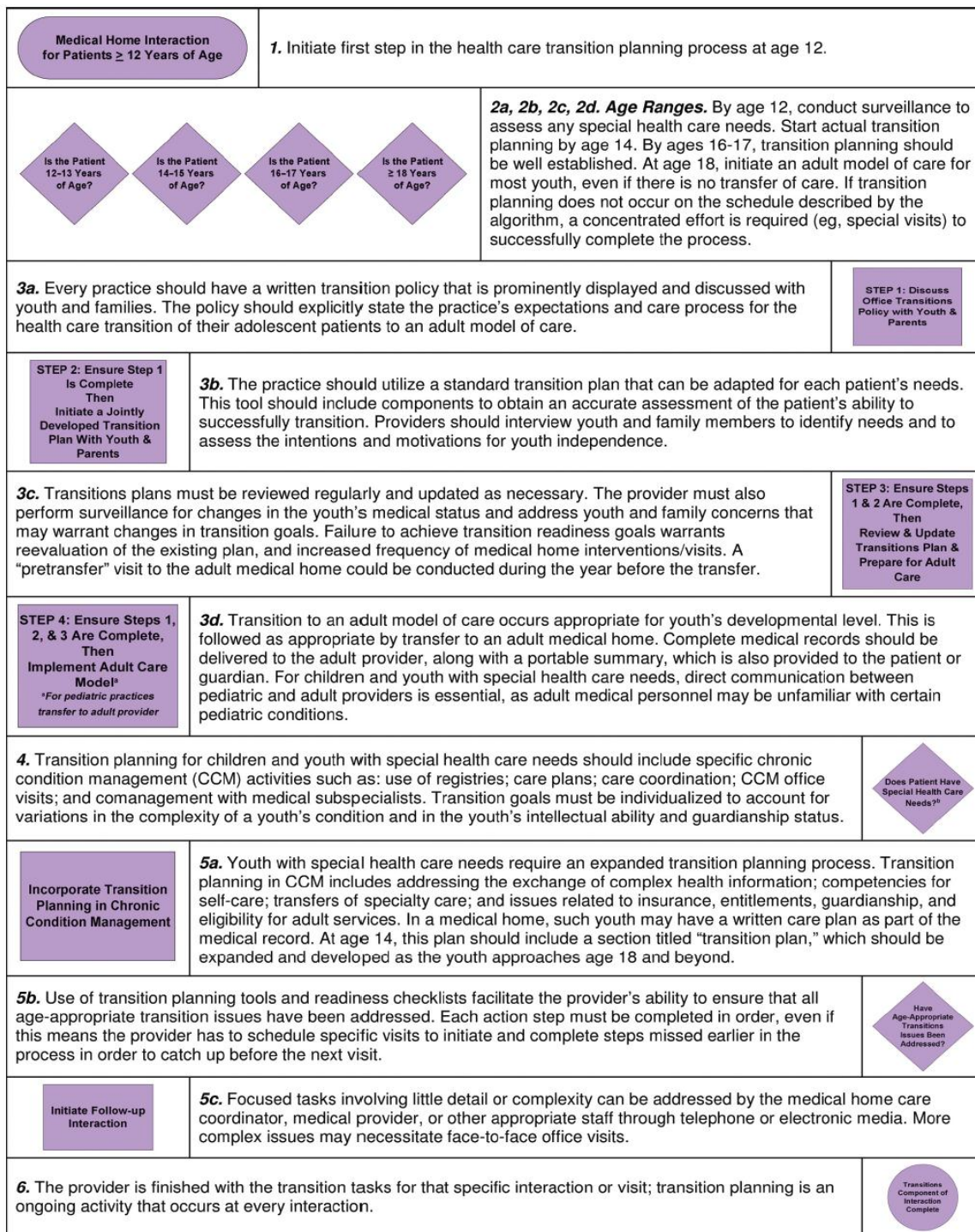
Sincerely,

Appendix C: Health Care Transition Planning Algorithm for all Youth and Young Adults within a Medical Home Interaction

FROM THE AMERICAN ACADEMY OF PEDIATRICS



APPENDIX 1



APPENDIX 1 CONTINUED

Available at <http://pediatrics.aappublications.org/content/early/2011/06/23/peds.2011-0969.full.pdf>

Appendix D: Georgia Family Fact Sheets

- **Aged, Blind and Disabled Medicaid** – Overview of the program and eligibility requirements.
- **Georgia Transition Manual, Georgia Department of Education**– A key to better post-secondary options for students with disabilities.
- **Health Care Financing Fact Sheet** – Overview of health care financing options for Georgians.
- **Health Transition Fact Sheet** – Information to help families understand and plan for health care transition.
- **Health Transition Plan Parent Worksheet and Youth Milestones Worksheet** – used to assist parents and youth with assessing health transition goals.
- **Medical Home Fact Sheet** – Information to help families understand the medical home.
- **Transition to Life after High School Fact Sheet** – Basic information and tips on the transition planning process.

Appendix E: Online Resource

- **AAP Coding Calculator** – this AAP coding calculator is used for general comparative purposes for the reimbursements of Evaluation and Management codes.
- **AAP EQIPP Medical Home for Pediatric Primary Care** – This Education in Quality Improvement for Pediatric Practice series provides child health professionals with practical strategies for implementing medical home in practice.
- **AAP/MCHB Building Your Medical Home Toolkit** – supports the health care professional's development and/or improvement of a pediatric medical home. It also prepares the provider to apply for and potentially meet the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition program requirements.
- **AAP Pediatric Coding Newsletter Online** – this American Academy of Pediatrics website offers a variety of coding resources for pediatricians.
- **Family Voices** - aims to achieve family-centered care for all children and youth with special health care needs and/or disabilities. Through their national network, they provide families tools to make informed decisions, advocate for improved public and private policies, build partnerships among professionals and families, and serve as a trusted resource on health care.
- **Georgia Department of Community Health Fee Schedule** – this link takes you to the Georgia Department of Community Health's web portal and provides information on fee schedules for services provided to those enrolled in Medicaid.
- **Got Transition** – this website offered by the National Health Care Transition Center is funded by the federal government to provide health care transition resources and research to improve the health care transition process for youth with disabilities nationwide.
- **Healthy and Ready to Work (HRTW) National Resource Center** -this site focuses on understanding systems, access to quality health care, and increasing the involvement of youth. It also includes provider tools and resources needed to make more informed choices. The HRTW project has ended but the site will remain available.
- **Healthy Transitions New York** – provides curriculum and tools to assist health care providers, youth and their families on how to raise awareness about developmental disabilities, improve communication, and build effective partnerships during the transition process.

- **Illinois Chapter American Academy of Pediatrics (ICAAP) Website** – host of information, training opportunities and tools for transitioning youth from pediatric to adult care.
- **Institute for Healthcare Improvement** - offers a wide range of resources and teaching tools to help health care professionals lead effective improvement efforts, enhance clinical outcomes, and reduce costs.
- **My Medical** – comprehensive record-keeping app for personal medical information.
- **Needy Meds** – information on patient assistance programs.
- **Parent to Parent of Georgia** - Provide services to children and youth with disabilities and their families. Services include an on-line data base of various resources, such as respite care, child care, or support groups, that are available in local areas, training sessions for parents on a wide variety of topics and a parent-to-parent matching program. Parent to Parent serves as the central office for:
 - Family to Family (F2F) Health Information, Center (HIC)
 - Georgia's Family Voices
 - Parent Training and Information Center (PTI)
 - Family Support 360 Project (Navigator 360 Project)
 - Babies Can't Wait Central Directory
- **Payment and Finance Section of the National Center for Medical Home Implementation** – this website offers resources for physicians on how to advocate and negotiate for improved and appropriate payment for services provided by a medical home.
- **Shared Care Plan**- no cost, web-based tool to assist patients with organizing and recording health information.

Appendix F: References

1. Health Care Transition, A Health Care Provider's Guide to Helping Youth Transition from Pediatric to Adult Care. Carolina Health and Transition (CHAT) 2010.
2. Clinical Report—Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home Pediatrics Volume 128, Number 1, July 2011.
3. "Current Status of Transition Preparation among Youth with Special Needs in the United States" Pediatrics, Volume 131, Number 6, June 2013.
4. "IEP Must Include Transition Plan To Prepare Teens For Adulthood" AAP News January 2013.



HEALTH CARE TRANSITION

FROM PEDIATRIC TO ADULT PRIMARY CARE

**GUIDE FOR PHYSICIANS TO SUPPORT YOUTH AND YOUNG ADULTS
WITH SPECIAL HEALTH CARE NEEDS**

Georgia Academy
of Family Physicians
www.gafp.org

Georgia Chapter,
American Academy
of Pediatrics
www.gaaap.org

Georgia Department of Public Health
Maternal and Child Health Section
www.dph.georgia.gov